Leave of Absence Form
Health Care Flexible Spending Account

Name (Last, First, MI)	
Agency/School District Name	**Employee ID**
Dates of Leave	**Daytime Phone #**

Leave Designation:

❑ FMLA Leave	❑ Short Term Disability	❑ Workers Comp
❑ Non-FMLA Leave	❑ Parental Leave	❑ Military

I request the below option for my Health Care FSA contributions (select one):

❑ **CATCH UP** - I elect to **catch-up contributions** to my Health Care FSA on my return from LOA. I understand that my period of coverage will extend throughout the LOA and claims for expenses incurred during my LOA **will be eligible** for reimbursement.

I also understand that during my LOA, my employer has agreed to make contributions to my Health Care FSA. I further understand that when I return to work, the amount of contributions my employer made on my behalf will be recalculated and deducted from my paychecks on a pretax basis. I consider this amount a debt I owe my employer.

I understand I may not change the underlying Health Care FSA election amount on account of commencing or returning from the LOA.

❑ **REVOKE** - I elect to **revoke contributions** to my Health Care FSA during my LOA. I understand my period of **coverage will end** as of the first day of my LOA and that **claims incurred after this date will not be eligible**.

I understand once my coverage is revoked, my ASIFlex Card will be immediately suspended.

I also understand that a new election may be made **within 31 days** of return to work, effective for coverage the first of the month following approval of the submitted form. I must forward a completed **ELECTION CHANGE FORM** to the **Statewide Benefits Office** if I wish to do so.

I understand I may not change the underlying Health Care FSA election amount on account of commencing or returning from the LOA.

I understand if I elected to revoke my Health Care FSA and are on LOA less than **31 days**, my election will automatically be reinstated upon my return and the amount of missed contributions recalculated and deducted from my paychecks on a pretax basis.

Employee Signature	Date

Does my Leave of Absence effect my Health Care FSA?

If Health Care FSA contributions are not received for two consecutive pay periods and no leave form has been filed, a hold will be placed on your account.

If you are on unpaid leave for **more than 30 consecutive days** and **do not elect to catch up** on contributions, your coverage **will be revoked** effective your last day worked.

What if I do not submit a Leave of Absence Form?

Your participation in the Health Care FSA will be revoked **after 30 consecutive days** of unpaid leave. Coverage will end as of the first day of leave and claims incurred after this date will not be eligible. Your ASIFlex Card will be immediately suspended.

It is the employee's responsibility to file Leave of Absence Form with the Statewide Benefits Office PRIOR to going out on leave.

Does my Leave of Absence effect my Dependent Care FSA?

Dependent Care expenses are not eligible for reimbursement during a period of leave. You may choose to stop your Dependent Care prior to going on leave by completing an Election Change Form. When you return to work, you will have **31 days** to reinstate your coverage.

For more information on Flexible Spending, visit the SBO website at de.gov/statewidebenefits.

FAILURE TO COMPLETE THIS FORM COULD RESULT IN A REDUCTION OF BENEFITS.

RETURN THIS FORM TO STATEWIDE BENEFITS OFFICE BY FAX, 302-739-8339.
PLEASE CONTACT STATEWIDE BENEFITS OFFICE, AT 1-800-489-8933 WITH QUESTIONS.